PHYSICIAN-LED HEALTHCARE FOR AMERICA

# AHA/FAH Factsheet: Erroneous, Incomplete, and Misleading

April 13, 2023

In March 2023, the American Hospital Association (AHA) and Federation of American Hospitals (FAH) commissioned "Select Financial, Operating and Patient Characteristics of Physician Owned Hospitals Compared to Non-Physician Owned Hospitals."[1] This factsheet of selected indicators claims, "Overall, these data indicate that compared to non-POHs, POHs generally treat a population that is younger, less complex or comorbid, and less likely to be dually eligible or non-white, and that POHs have higher margins and lower unreimbursed and uncompensated care costs as a percent of net patient revenue compared to non-POHs."

As stated in the title of the document, AHA/FAH did not use a complete dataset to compare POHs and non-POHs. Instead, several random datapoints were selected that are favorable to AHA/FAH to present in the so-called "factsheet." Furthermore, the document does not detail its methodology and rationale to select these random datapoints. Overall, selected datapoints in the so-called "factsheet" are inaccurate, incomplete, and misleading.

## ERRONEOUS/INACCURATE

**AHA and FAH's findings are NOT "apples-to-apples" comparisons.** Many POHs have unique characteristics compared to large hospital systems that need to be accounted for to create an apples-to-apples analysis. **AHA and FAH's findings conflict with other recent analyses.** The findings presented to AHA and FAH are inconsistent with other published data. These inconsistencies raise questions about their assumptions and vague methodology underlying the AHA and FAH findings and the overall accuracy of the analysis.

1. **Emergency care figures need to be reassessed.**

   **AHA/FAH:** Percentage of Medicare Inpatient Claims with Emergency Room Services, FY 2022 (Figure 7) shows non-POHs have a higher percentage of Medicare inpatient claims with emergency room services compared to POHs.

   **Issue**: Hospitals without emergency rooms should not be included in this calculation. Including hospitals without emergency room services deflates the percentage for POHs and is an inaccurate comparison between the two populations.

2. **Pandemic care figures need to be reassessed.**

[1]Dobson, Al, Ph.D., et al. 2023. "Select Financial, Operating and Patient Characteristics of Physician Owned Hospitals Compared to Non-Physician Owned Hospitals." Dobson | DaVanzo. March 2023.

**AHA/FAH:** Percentage of Medicare Inpatient Claims for Patients with COVID-19, FY 2022 (Figure 12) shows non-POH have a higher percentage of inpatient claims for patients with COVID-19

**Issue**: During the pandemic, many POHs played a valuable role in providing COVID-19 care and were able to reduce the burden on their partner community hospitals when community hospitals couldn't perform surgery. However, not all POHs handled COVID-19 cases because the type of care required was not their specialty; some hospitals were forced to close. In the AHA/FAH analysis, hospitals forced to close during the pandemic should not be included in the calculation. Including these specialty hospitals deflates the percentage of POHs and is an inaccurate comparison between the two populations.

### 3. The POH readmission rate is lower than reported.

**AHA/FAH:** The Percentage of Hospitals with Medicare Maximum Readmission Penalty of 3%, FY 2023 (Figure 2) shows that non-POHs have a lower share of hospitals with a readmission penalty compared to POHs.

**Issue**: PHA's reported readmission rate is 0.4%.[2] Moreover, in specialty areas like hip and knee replacements, 90% of POHs (n=50) had a 5% readmission rate or less compared to only 59.9% of non-POHs (n=613).[3]

### 4. The share of rural POHs is higher than reported.

**AHA/FAH:** Percentage of Hospitals Located in Rural Areas, FY 2023 (Figure 3). AHA and FAH report that 6.8% of POHs are located in rural areas.

**Issue**: Our research found that 13% are located in rural areas, in other words, about one in every eight physician-led hospitals is in a rural setting.[4] This figure is impressive, given barriers to entry for small physician-led hospitals to open and operate in rural areas. According to PHA Board Member Robb Linafelter, "Having physician ownership in a rural setting is not always financially feasible because of the amount of capital it takes to build and own a facility and the smaller number of doctors in the rural setting."

## INCOMPLETE

**AHA and FAH findings exclude important groups of patients, programs, and services.** Hospitals provide a wide range of services in the communities they serve. The data presented by AHA and FAH excludes large portions of patients, programs, and services. These gaps raise concerns about cherry-picking favorable data to present in the factsheet.

### 1. Age: The factsheet excludes claims data for patients under age 85.

**AHA/FAH:** The Percentage of Medicare Inpatient Claims for Patients who are 85 Years or Older, FY 2022 (Figure 10) shows that non-POHs have a larger share of Medicare inpatient claims. However, they only examine a small portion of the Medicare population.

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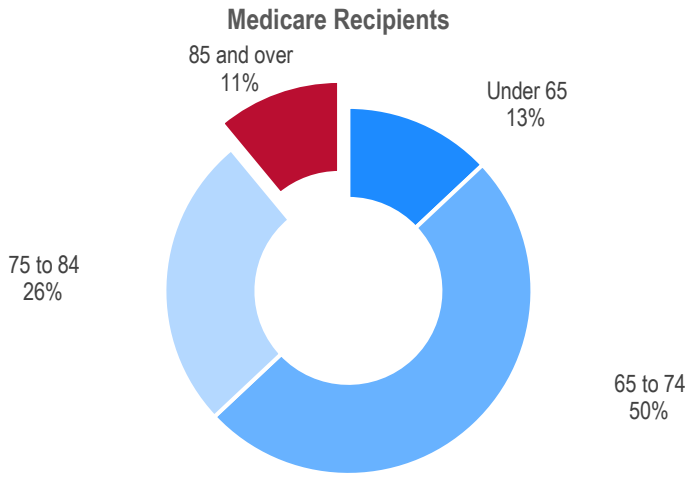
[2] https://khn.org/news/hospital-penalties/readmissions/

[3] Analysis of 2022 American Hospital Directory data. Only includes hospitals with any readmission rate (excludes hospitals with no readmissions)

[4] Pham, Nam D., Ph.D., and Mary Donovan. 2022. "The Economic and Social Benefits of Physician-led Hospitals." ndp analytics.

**Issue:** Medicare serves a much wider population. According to CMS, only 11% of Medicare recipients are age 85 or older (Figure below).[5]



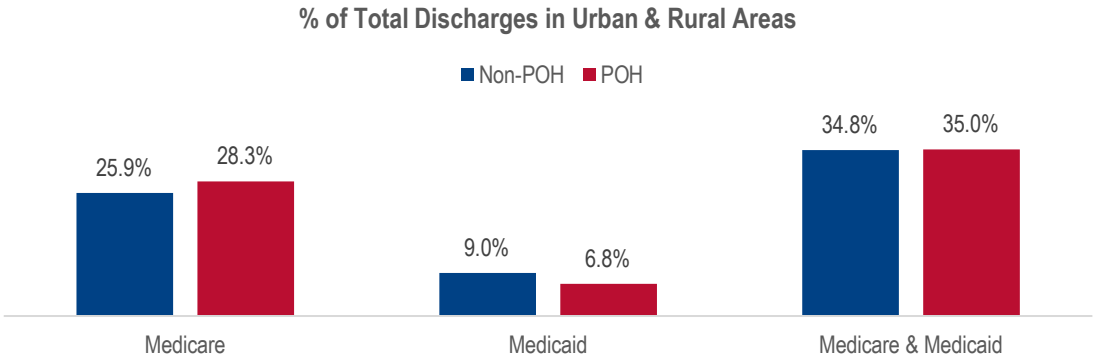

## 2. Programs: The factsheet excludes overall claims data for Medicare.

**AHA/FAH:** The factsheet excludes overall performance for Medicare claims; it only provides overall performance of Medicaid (Figure 1). Instead, the factsheet shows non-POHs outperform POHs in select subgroups, including Emergency Room Services (Figure 7) as well as Patients with Dual Eligibility (Figure 8), Age 85 and Older (Figure 10), Non-White (Figure 11), and with COVID-19 (Figure 12).

**Issue:** The factsheet didn't include the overall statistics for the Medicare program because non-POHs do not outperform POHs. (Figure below)

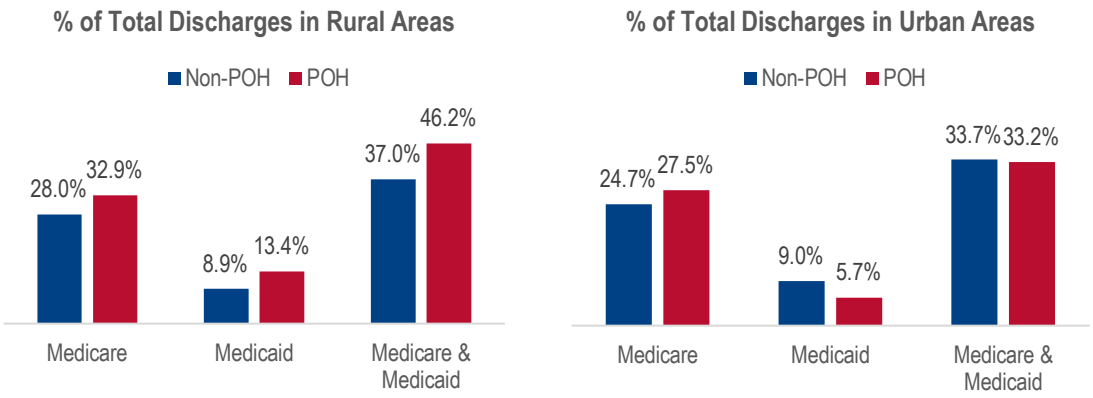
**Medicare and Medicaid Discharges[6]**

Panel A. Non-POHs outperform POHs for Medicare




[5] https://data.cms.gov/infographic/medicare-beneficiaries-at-a-glance
[6] Analysis of 2022 American Hospital Directory data.

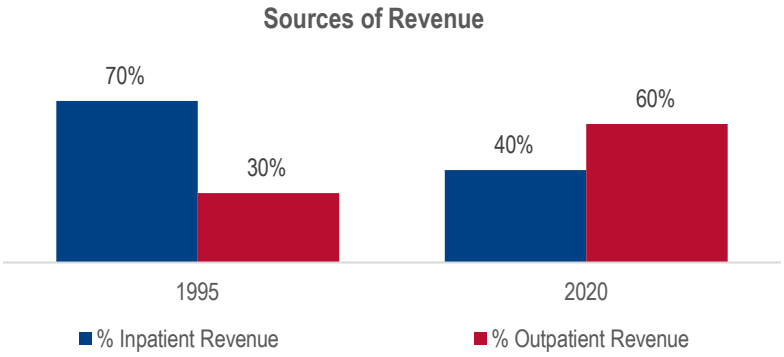
Panel B. Breakdown for Rural & Urban Areas




3. **Services: The factsheet excludes claims data for outpatient services.**

**AHA/FAH:** The factsheet focuses on inpatient services only.

**Issue:** Outpatient services provide important care to patients. These services are no longer a small portion of hospital portfolios. Research from the Healthcare Financial Management Association found that in 2020, outpatient service accounted for 60% of revenue (HFMA chart).[7] Many specialty hospitals, like orthopedic surgery centers, focus on outpatient care, which provides cost savings for patients and government healthcare programs alike. (Figure below)




## MISLEADING

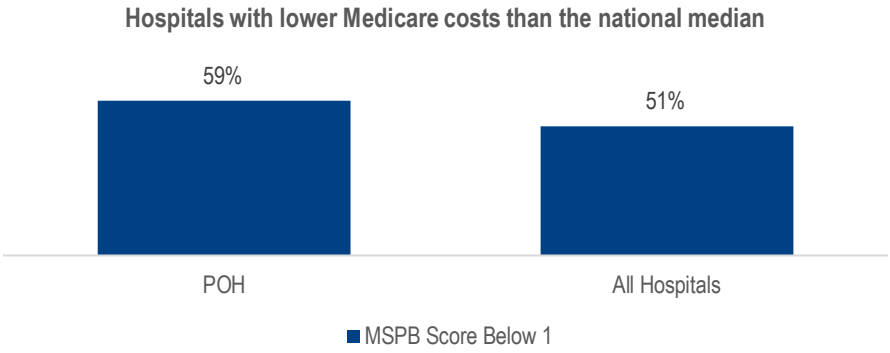
**POH margins reflect efficiency NOT overcharging.** The metrics presented by AHA and FAH appear to assert that POHs charge higher prices and/or serve patients in better health, thus affording POHs higher margins and lower rates of uncompensated care. These metrics are irrelevant and ignore the actual cost-savings to Medicare provided by POHs.

1. **POHs have lower costs of care – even after accounting for differences in patient characteristics, complexity, and location.**

[7] https://www.hfma.org/cost-effectiveness-of-health/financial-sustainability/why-the-physician-s-office-not-the-ed-is-a-health-system-s-tru/

**AHA/FAH:** Patient Care Margin, FY 2021 (Figure 4) and Overall Medicare Margin, FY 2021 (Figure 5) and Total Unreimbursed and Uncompensated Care Costs as Percent of Net Patient Revenue, FY 2021 (Figure 6) show that POHs have higher margins and lower unreimbursed care compared to non-POHs.

**Issue**: These metrics are not an appropriate measure for Medicare. Alternatively, the conversation should be about costs to Medicare and overall spending. CMS' Medicare Spending per Beneficiary (MSPB) measure evaluates a hospital's efficiency relative to the national median. Unlike other cost comparisons, MSPB assesses the cost of services performed by hospitals and other healthcare providers immediately before, during, and after a beneficiary's hospital stay and controls for price variation and risk factors such as patient case mix and geography. **According to CMS, the MSPB scores help "to increase the transparency of care for consumers and recognize hospitals that are involved in the provision of high-quality care at lower cost to Medicare.**" Physician-led hospitals outperform their counterparts in this measure. **Of the hospitals with MSPB data, 51% of all hospitals had lower Medicare costs than the national median hospital in 2022 (the MSPB measure was lower than 1.0). In comparison, 59% of physician-led hospitals have lower Medicare costs per beneficiary than the national median hospital.**[8] (Figure below)




## 2. POHs create cost savings for Medicare.

**AHA/FAH: (Same as above)** Patient Care Margin, FY 2021 (Figure 4) and Overall Medicare Margin, FY 2021 (Figure 5) and Total Unreimbursed and Uncompensated Care Costs as Percent of Net Patient Revenue, FY 2021 (Figure 6) show that POHs have higher margins and lower unreimbursed care compared to Non-POH.

**Issue**: These metrics are not an appropriate measure for Medicare. Alternatively, the conversation should be about Medicare spending and cost savings. Physician-led hospitals provide patients with efficient quality care. These efficiencies help manage costs and generate savings for government programs, including Medicare. Procedures that create the most cost savings include orthopedic surgery, like hip and knee replacements, and cardiovascular surgery, such as coronary bypass or cardiac valve replacement. **Our research found that healthcare services provided by physician-led hospitals saved Medicare $217.1 million. The average savings per patient is $1,500**.[9]

## 3. POHs do serve a diverse population, contrary to AHA and FAH's assertions.

[8] Pham, Nam D., Ph.D., and Mary Donovan. 2022. "The Economic and Social Benefits of Physician-led Hospitals." ndp analytics.
[9] Pham, Nam D., Ph.D., and Mary Donovan. 2022. "The Economic and Social Benefits of Physician-led Hospitals." ndp analytics.

**AHA/FAH:** Percentage of Medicare Inpatient Claims for Patients with Dual Eligibility, FY 2022 (Figure 8), Mean Number of CC/MCCs per Medicare Claim, FY 2022 (Figure 9), and Percentage of Medicare Inpatient Claims for Patients Who are Non-White, FY 2022 (Figure 11), show that non-POHs have more claims than POHs in these categories.

**Issue**: Research shows this is not the case. The peer-reviewed 2015 BMJ study demonstrates that POHs have the same Medicaid market share as other hospitals and minimal differences in patient characteristics.[10]

## METHODOLOGY

In their factsheet, AHA and FAH do not provide their rationale to select a handful of indicators and do not provide the methodology to calculate these selected indicators. For example:

1. Total Revenue (Appendix; page 7): AHA and FAH excluded donations, contributions, investment income, and COVID-19 funds without providing an explanation.

2. Margin (Appendix; page 7; footnotes 9 and 10): AHA and FAH do not provide the rationale of their exclusions of certain hospitals to calculate patient margin and overall Medicare margin.

[10] https://www.bmj.com/content/351/bmj.h4466